STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint #IN00123081. Survey dates: January 28, 29, 30, 31, and February 1, 5, 6, 7, 2013 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Survey team: Amy Wininger, RN TC Barb Fowler, RN Diane Hancock, RN Census bed type: SNF: 12 SNF/NF: 84 Total: 96 Census payor type: Medicare: 22 Medicaid: 67 Other: 7 Total: 96 Sample: 3 These deficiencies also reflect state findings	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after March 1, 2013.**Thank you,Judith Carter, Executive Director North Park Nursing CenterEvansville Indiana 47710812-425-5243	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in accordance with 410 IAC 16.2. Quality review completed on February 14, 2013, by Jodi Meyer, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on interview and record review, the facility failed to ensure 2 of 3 residents reviewed for choices, in the sample of 5 who met the threshold, were able to choose how often they received showers. (Resident #62, Resident #118) Findings include: 1. During interview of Resident #62 on 1/28/13 at 2:38 p.m., he indicated he was supposed to get 2 showers a week but had only had 2 showers and one bed bath since he was admitted. He indicated he had not refused any showers and would have liked to have the two showers a week at least. Resident #62's clinical record was reviewed on 2/1/13 at 12:30 p.m. The record indicated the resident was admitted to the facility on 12/22/12 with diagnoses including, but not limited to, diabetes mellitus and osteomyelitis left ankle.	F0242	**F242** Self Determination- Right to make choices 1.Resident #62 discharged on 2/2/2013 and resident #118 discharged on 2/4/2013. 1.All residents have the potential to be affected by the alleged deficient practice. All residents were interviewed using the Activity Questionnaire regarding shower choices. Careplans were updated to reflect resident preference regarding showers as needed. Nursing staff were in serviced 2/12/13 per SDC on the shower schedule, resident preferences and documentation related to showers. Shower schedules have been audited to ensure that each resident is scheduled for the number and time of their shower (minimum of two showers per week) and revisions were made to include resident preferences as indicated. 3. Nursing staff were in serviced 2/12/13 per SDC on the shower schedule, resident preferences and documentation related to showers. Master shower	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #62's admission Minimum Data Set [MDS] assessment, dated 12/29/12, indicated he scored a 14 out of 15 on the Brief Interview for Mental Status [minimal cognitive impairment]. The resident had a care plan, dated 1/3/13, including, but not limited to, the following interventions: "Encourage resident to make choices in care such as clothing, shower time preference, etc..." "Provide shower 2 times per week, partial bath in between." The Activities of Daily Living records were reviewed as part of the record review. The records indicated the resident received partial baths on all days except the following: 1/1/13 BB [bed bath] 1/4/13 BB 1/11/13 shower 1/21/13 B [bed bath] 1/24/13 shower 1/29/13 shower 2. Resident #118 was interviewed on 1/29/13 at 9:16 a.m. Resident #118 indicated during interview he received two showers a week. He indicated he preferred to get up every day around 5:00 a.m. and shower, he'd done that all his life. He indicated, "they are adamant, only 2 showers a week."		schedule will be updated as needed per DNS/designee upon completion of the admission questionnaire and as indicated per resident interview results. Charge nurses will conduct rounds daily to ensure residents are offered and receiving showers per resident preferences. Nursing staff will be required to sign the shower sheet in acknowledgement of completion of the shower and/or refusal of shower. 4. DNS/ designee will complete resident interview monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure residents have choices in care. Results of resident interview monitoring tool will be reviewed in the monthly CQI meeting for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Resident #118's clinical record was reviewed on 2/1/13 at 12:25 p.m. The resident's admission Minimum Data Set [MDS] assessment, dated 12/14/12, indicated he scored a 15 out of 15 on the Brief Interview for Mental Status, indicating no cognitive impairment.

The resident's care plan included, but was not limited to, a care plan for activities of daily living, self care deficit, dated 12/21/12. Interventions included, but were not limited to, the following: "Encourage resident to make choices in care such as clothing, shower time preference, etc." "Provide shower two times per week, partial bath in between.

The Activities of Daily Living records were reviewed for January, 2013 and indicated the resident received a partial bath on all days except the following when he received a shower: 1/1/13, 1/4/13, 1/9/13, 1/11/13, 1/13/13, 1/16/13, 1/24/13.

3. On 2/6/13 at 2:00 p.m., the Director of Nurses [DoN], indicated Resident #62 had complained about not getting a shower. He had an intravenous line in one arm and a wound they were treating on his other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	foot. The direct care staff did not think they could give him a shower; she indicated they were instructed on how to cover the areas for showers and she thought the issue had been resolved. She thought it was 3 or 4 weeks ago it had been addressed. After reviewing the shower documentation, the Nurse Consultant and DoN indicated they had found some discrepancies in the shower list and the nurse aide assignment sheets for when residents were to get showers. This review had occurred 2/5/13. 3.1-3(u)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING _____ B. WING 00	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and record review, the facility failed to ensure resident rooms and/or bathrooms were clean in that, 9 of 34 resident rooms and/or bathrooms were soiled. (Room #112, Room #114, Room #115, Room #149, Room #150, Room #151, Room #152, Room #154, Room #155) Findings include: 1. Observation of room #149 on 1/29/13 at 9:52 a.m., indicated the bathroom floor had a liquid in the floor around the base of the commode, 2. Observation of room #150 on 1/29/13 at 9:33 a.m., indicated the bathroom floor was dirty with a build-up of dirt in the corners and around the baseboard of the floor. 3. Observation of room #151 on 1/29/13 at 9:31 a.m., indicated the bathroom floor was wet around the base of the commode, the bathroom had a strong urine odor, and a small brown smear was on the commode seat.	F0253	**F253** Housekeeping & Maintenance Services 1. Resident rooms/ bathrooms #112,114,115,149,150,151,152,154,155 have been cleaned. Side rail in room 154 was secured. 2. All residents have the potential to be affected by the alleged deficient practice. All resident rooms/bathrooms were thoroughly cleaned. Housekeeping staff were in serviced on 2/25/13 per housekeeping supervisor related to guidelines for cleaning resident rooms and bathrooms. Facility audit completed to ensure that side rails were secure with corrective action as needed. 3. Housekeeping staff were in serviced on 2/25/13 per housekeeping supervisor related to guidelines for cleaning resident rooms and bathrooms. Housekeeping and maintenance services will be provided to maintain a sanitary, orderly and comfortable interior. Rounds will be conducted daily per Housekeeping supervisor/ designee to ensure rooms are cleaned according to the facility cleaning guidelines. If rooms are not cleaned appropriately rooms will be recleaned to ensure the room is cleaned according to the	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Observation of room #152 on 1/29/13 at 9:28 a.m., indicated the bathroom floor was sticky and dirty. 5. Observation of room #154 on 1/29/13 at 9:27 a.m., indicated the bathroom floor was sticky and dirty and the siderail was attached properly but was loose on the resident's right side of the bed. 6. Observation of room #155 on 1/29/13 at 8:56 a.m., indicated the bathroom floor was sticky and dirty with no paper towels and an empty glove box in the bathroom. 7. Room #115 was observed on 1/28/13 at 2:52 p.m. There was dirt and debris behind the bedroom door. 8. Room #112 was observed on 1/29/13 at 1:42 p.m. The bathroom floor was soiled with a gray build-up in the corners and edges. There was a		standards. Rounds will be conducted daily per Maintenance Director/ designee to ensure side rails are secure in all rooms. 4.Housekeeping supervisor/ designee will complete housekeeping monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that resident rooms and bathrooms are clean. Failure to comply with guidelines will result in disciplinary action up to and including termination. Maintenance Director/ designee will complete side rail monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months. Results of housekeeping monitoring tool and side rail monitoring tool will be monitored in the monthly CQI meeting for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3 inch rust stain on the back wall of the bathroom. 9. Room #114 was observed on 1/29/13 at 1:34 p.m. There was a large brown smear on the front of the toilet and debris in the corner behind the bedroom door. The "Cleaning Guidelines," obtained on 2/7/13 at 8:30 a.m from the DoN [Director of Nursing], indicated the resident's rooms and restrooms are to be cleaned and disinfected and the paper towels are to be replenished daily. The guidelines indicated the commonly touched areas were to be cleaned and disinfected and the exterior of the toilet was to be wiped daily. 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, interview and record review, the facility failed to ensure comprehensive assessments accurately reflected the residents' status, for 7 of 44 Stage 2 sampled	F0272	**F272** Comprehensive Assessments 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents, in that psychoactive medications, dental status, and skin issues were not reflected on the assessments. (Resident #29, Resident #111, Resident #65, Resident #124, Resident #25, Resident #32, Resident #50) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Resident #29 diagnoses included, but are not limited to, bipolar disorder, anemia, uterine cancer, anxiety and an abdominal aortic aneurysm. The annual MDS, dated 4/6/12, indicated Resident #29 had no dental problems. The assessment did not indicate the resident had dentures. The quarterly MDS, dated 11/14/12, did not indicate any dental issues. Resident #29 was interviewed on 1/29/13 at 9:17 a.m. On interview the resident indicated she had loose dentures. Resident #29 indicated her dentures were at least 20 years old and she had not been to the dentist in quite some time. The resident indicated she had been able to chew without difficulty but probably needs some adjustments to her dentures.		time. MDS assessments modified and resubmitted as indicated for residents'#9, #11 #65, #124, #25, #32 and #50. 2.All residents have the potential to be affected by the alleged deficient practice.Facility audit completed to ensure that dental consents have been obtained and dental services scheduled as indicated. IDT and nursing staff in serviced on 2/26/13 per SDC related to dental services. Audit of assessments pertaining to psychotropic medications and skin issues were completed to ensure assessments reflect the resident's status. 3. IDT and nursing staff in serviced on 2/26/13 per SDC related to dental services. IDT will review each care plan and assessment during the resident reference period, to compare the MDS assessment with the resident care plan and current resident needs. DNS/designee will reviewed the assessments to ensure accuracy prior to transmission. 4.DNS/designee will complete assessment monitoring tool 5x week for 2 weekse monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure dental consents and services are provided as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Resident #111's record was reviewed on 1/30/13 at 1:00 p.m. Resident #111 had a diagnoses of, but not limited to, dementia,anxiety, hypertension, and hyperlipidemia. Resident #111's admission MDS indicated the resident had no dental issues. The quarterly MDS, dated 12/21/12, also indicated the resident did not have any dental issues. Resident #111's family and POA [power of attorney] was interviewed on 1/28/13 at 12:41 p.m. Resident #111's family/POA indicated the resident had loose teeth and had lost some of her teeth since coming to the facility. She felt the resident's gums had "shrank." Resident #111's family/POA indicated the resident had visited the dentist in the past but had not had a dental visit since her admission to the facility in April, 2012. Interview with SW #1 on 2/1/13 at 10:44 a.m., indicated that residents #29 and #111, had not had a dental visit since being admitted to the facility. SW #1 indicated she did not know the either resident had any dental issues. SW #1 indicated she could not locate the consent for dental services that is signed when the resident is admitted		indicated. Results of assessment monitoring tool and dental service monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the facility. SW #1 indicated she would need to follow up with each of the resident's charts to ensure the residents have their consents signed for services and she would speak with the resident's family to allow the resident to have a dental appointment. SW #1 indicated the resident could be visited by a dentist in the facility or the resident could visit their own dentist. Interview with SW #1 on 2/7/13 at 9:56 a.m., indicated she had "looked through" both of the resident's medical records and was unable to locate where either resident had a dental visit. 3. Resident #65's record was reviewed on 1/30/13 at 3:45 p.m. Resident # 65 had diagnoses of, but not limited to,moderate dementia, diabetes mellitus type 2, anxiety, and GERD [gastroesophageal reflux disease]. Resident # 65 had an order, dated 8/24/12, for Seroquel [an antipsychotic medication] 25 mg 1 tablet by mouth daily at bedtime. The quarterly MDS assessment, dated 11/30/12, indicated the resident had not been on a antipsychotic medication but had been receiving an antidepressant medication for 7 days prior to the MDS assessment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Resident #124's record was reviewed on 1/31/13 at 9:05 a.m. Resident #124 had a diagnoses of, but not limited to, psychosis and dementia with behavioral disturbances. Resident #124 had been hospitalized from 11/6/12 through 12/14/12 for behaviors and returned to the facility on 12/14/12 with the following medications ordered: Risperdal Const [an antipsychotic medication] 12.5 mg [milligrams] / 2 ml [milliliters] IM [intramuscularly] every 2 weeks, which had been started on 12/4/12. Remeron [an antidepressant medication] 15 mg p.o. [orally] at bedtime, which had been started on 12/1/12. Ambien [a hypnotic medication] 5 mg p.o. once a day prn [as needed], which had been started on 12/1/12. The resident had been on Risperdal liquid 0,5 mg/0,5 ml - give 0.5 ml p.o. twice a day with meals started on 12/8/12 and discontinued on 12/22/12. The admission MDS, dated 12/21/12, did not indicate the resident had received any of the above medications during the last 7 days or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	since admission/entry if less than 7 days. The 30 day scheduled MDS assessment, dated 1/9/13, indicated the resident received an antipsychotic during the last 7 days or since admission/entry if less than 7 days. 5. Resident #25's record was reviewed on 2/1/13 at 2:45 p.m. Resident #25 had a diagnoses of, but not limited to, intertrochanteric fracture of the right hip, right below the knee amputee, Alzheimer's disease, dementia with behavior disturbances,epilepsy, and CVA [cerebral vascular accident]. Resident #25 was admitted with a surgical incision on his right hip area. The admission MDS assessment, dated 8/23/12, indicated a clinical assessment of the resident's skin conditions had been performed but did not indicate the resident had a scar over a bony prominence, or a non-removable dressing/device. The discharge MDS assessment, dated 11/24/12, did not indicate the resident had a scar over a bony prominence or a non-removable dressing/device. Interview with the MDS Coordinator on 2/1/13 at 11:20 a.m., indicated he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	obtains the chart upon admission and "goes through it" for orders. The MDS Coordinator did not give a reason why MDS was incorrect for the skin condition assessment for resident #25. The MSD Coordinator did not give a reason why the MDS was incorect for residents #29, 65, 25, and 124. The MDS Coordinator indicated he was hired by the facility as an assistant MDS Coordinator in April, 2012, and after beginning employment, the previous MDS Coordinator left. 6. Resident #32 was observed to be sleeping in a chair in the activity area on 1/30/13 at 11:00 a.m. The resident was observed to be in a dining/activity area for exercise activity. She was very sleepy looking, and not participating in the activity. At 10:27 a.m. on 1/31/13, the resident was observed in her room in her chair sound asleep. Resident #32's clinical record was reviewed on 1/31/13 at 10:10 a.m. The resident was admitted to the facility on 7/15/11 with diagnoses including, but not limited to, nonorganic psychosis, anxiety state, depression, neuralgia, hypertension, dysrhythmia, congestive heart failure,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cerebrovascular disease, and arthropathy. The physician's orders, signed 1/29/13, included, but were not limited to, the following: "Alprazolam [antianxiety] 0.25 mg 1 [one] po daily at bedtime *hold for sedation* since 7/15/11 Lexapro [antidepressant] 20 mg po daily Risperidone [antipsychotic] 0.25 mg one twice a day since 8/25/11" Resident #32's annual Minimum Data Set [MDS] assessment, dated 6/12/12, indicated the resident was receiving an antianxiety medication and an antidepressant medication but failed to indicate the resident was receiving an antipsychotic medication. Resident #32's quarterly MDS, dated 11/21/12, indicated the resident was receiving an antianxiety medication and an antidepressant, but failed to indicate the resident was receiving an antipsychotic medication. The Director of Nurses and Nurse Consultant indicated during interview on 2/6/13 at 2:00 p.m., the medications should be indicated on the MDS.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7. Resident #50's clinical record was reviewed on 1/30/13 at 11:05 a.m. The resident was admitted to the facility on 12/2/12, with diagnoses including, but not limited to, hyperlipidemia, dementia and osteoporosis. She was transferred out to a geriatric psychiatric unit on 12/5/12, and returned to the facility on 12/21/12. Record included, but were not limited to, physician's orders, dated 12/24/12 at 10:30 a.m., for the following medications: Haldol [antipsychotic medication] 5 milligrams [mg] at 1600 [4:00 p.m.] that date and every 6 hours as needed for extreme anxiety/agitation. Geodon [antipsychotic medication] 40 mg by mouth daily to start 12/25/12. Upon admission 12/21/12, the resident also had orders for Lorazepam [antianxiety medication] 0.5 mg by mouth every 4 hours as needed. Review of the Medication Administration Record indicated the resident received lorazepam on 12/23/12, 12/25/12, and 12/26/12. Resident #50's admission Minimum Data Set [MDS] assessment, dated 12/28/12, included, but was not limited to, the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Antipsychotic medication received 7 days Antianxiety medication, none received 3.1-31(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a care plan for 1 of 3 residents reviewed for ADL's [activities of daily living] in the Stage 2 sample of 44 residents who were reviewed for care plans. (Resident #65) Findings include: Resident #65's record was reviewed on 1/30/13 at 3:45 p.m. Resident # 65 had diagnoses of, but not limited to,moderate dementia, diabetes mellitus type 2, anxiety, and GERD	F0279	**F279** Develop Comprehensive Care Plans 1. ADL care plan developed for resident #65. 2. All residents with self care deficit have the potential to be affected by the alleged deficient practice. Facility audit completed for to ensure care plans have been developed to address residents' need for ADL assistance. IDT in serviced 2/28/13 per RAI Specialist related to development of comprehensive care plans.	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[gastroesophageal reflux disease]. During the resident's chart review on 1/30/13 at 3:45 p.m., the resident did not have a care plan to address her need for ADL assistance. Resident #65's "Resident Care/Need Sheet" [the CNA assignment sheet] indicated she needed the assistance of 1 person for her ADL's and had a transfer bar to the right side of her bed. The transfer bar was to be highlighted/textured for increased safety awareness for the resident. The sheet indicated the resident used a rolling walker, had to be "set-up" for eating, and needed encouragement every 2 hours to go to the bathroom. The quarterly MDS [Minimum Data Set] assessment, dated 11/30/12, indicated the resident needed extensive assistance of 1 person with bed mobility, extensive assistance of 1 person for transfers, extensive assistance of 1 person for dressing, extensive assistance of 1 person for toileting, extensive assistance of 1 person for personal hygiene,and physical assistance in part of bathing activity of 1 person. The MDS assessment indicated the resident was not steady and only able to stabilize with staff assistance for moving from seated to standing		1.IDT in serviced 2/28/13 per RAI Specialist related to development of comprehensive care plans. All residents are assessed at admission, quarterly and with significant change for self care performance, those found to be deficient will have a care plan initiated for ADL assistance. Every resident has a care plan review quarterly by the IDT team to ensure the assessment and care plan are accurate for each resident's ADLs. 4. DNS/ designee will complete the care plan monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that care plans address activities of daily living. Results of care plan monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	position, walking, turning around, moving on and off the toilet, and surface to surface transfers. The MDS assessment indicated the resident was frequently incontinent of urine. The "ADL's" record for January, 2013, indicated the resident is a 1-2 person assist for bed mobility, transfers, eating, and toilet use. The record indicated the resident is incontinent 1-2 times a day. Interview with LPN #1 on 2/5/13 at 9:30 a.m., indicated the resident is up with her walker but is a 1 person assist with her bathing and dressing. Interview with the DoN [Director of Nursing] on 2/6/13 at 3:30 a.m., indicated she did not know the resident did not have a care plan for her ADL deficits and most of the residents in the facility should probably have a self-care deficit care plan. The policy for Care Plan Review and Maintenance, dated 8/2011, and obtained from the DoN on 2/7/13 at 8:30 a.m., indicated it is the policy of the facility that each resident will have a comprehensive care plan developed based on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive assessment. The policy indicated the care plan review will be based on the MDS schedule for those residents who had an admission, annual, significant change, quarterly, or Medicare MDS completed at a minimum of every 90 days. The policy indicated the care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences, or family input. 3.1-35(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview, and record review, the facility failed to ensure a resident with an indwelling urinary catheter received care according to the care plan, in that, 1 of 1 residents reviewed for having an indwelling urinary catheter, in a sample of 3, did not have the catheter changed according to the plan of care. (Resident #B) Findings include: The clinical record of Resident #B was reviewed on 01/30/13 at 1:58 p.m. The Physician Admission Orders dated 08/09/12 included, but was not limited to, the following order "...change f/c [indwelling urinary catheter] q [every] month et [and] prn [as needed] occlusion..." The August 2012 TAR [Treatment Administration Record] lacked any documentation the catheter had been changed between 08/09/12 and	F0282	**F282** Services by qualified person/ per care plan 1.Resident B discharged from facility on 1/17/13. 1.All residents requiring the use of indwelling urinary catheter have the potential to be affected by the alleged deficient practice. An audit was completed of the identified resident's records to ensure that catheters had been changed and/or were scheduled to be changed in accordance to current physician order and plan of care. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians orders. 3. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians' orders. Catheters will be maintained and changed per physicians' orders by DNS/designee monitoring the TAR. DNS/designee will monitor by reviewing physician orders to ensure catheters are changed per order. DNS/Designee will ensure catheter care will be included in the residents' comprehensive plan of care.	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	08/31/12. The September 2012 TAR lacked any documentation the catheter had been changed between 09/01/12 and 09/19/12. The TAR included handwritten notes "changed on 09/19/12" and "Change Foley cath [an indwelling urinary catheter] on 09/28/12 then q 6 weeks. due again Nov. 9, 2012." The date of Nov 9, 2012 had been crossed through and an undated, handwritten note above indicated, "Oct 31st 2012." (The time frame between catheter changes equaled 6 weeks.) A physician telephone order dated 09/19/12 indicated an order for "...change Foley catheter every 6 weeks..." The October 2012 TAR included, but was not limited to, an order for "Change Foley catheter every month and as needed occlusion." The entry included a handwritten note that indicated, "changed 09/19/12 and due nov. 9" The TAR lacked any documentation the catheter had been changed during October 2012. The November 2012 TAR included, but was not limited to, an order for "Change Foley catheter every month		4. DNS /designee will complete catheter monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that catheters are changed according to physicians order. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of catheter monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and as needed occlusion." The TAR indicated the catheter had been changed on November 9, 2012 (The time frame between catheter changes equaled 7 weeks and 2 days) A Care Plan for indwelling catheter dated 10/29/12 included, but was not limited to, an intervention of, "...change catheter per MD order..." During an interview on 02/05/13 at 8:30 a.m. the DoN [Director of Nursing] indicated she could provide no documentation the catheter had been changed between 08/09/12 and 09/19/12 or between 09/28/12 and 11/09/12. She further indicated, at that time, it was standard practice for the facility to change the catheter according to the Physician's orders. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled residents with pressure sores, in the sample of 6 who met the threshold, received treatment and services to prevent infection and promote healing, in that the ordered treatment was not provided and infection control practices were not followed. (Resident #9) Finding includes: Resident #9's clinical record was reviewed on 1/30/13 at 2:00 p.m. The resident was admitted to the facility from the hospital on 12/19/12 with diagnoses including, but not limited to, endometrial cancer and multiple sclerosis. The resident was admitted to the facility with a history of a chronic pressure area on her left	F0314	**F314** Treatment/Services to prevent / heal pressure ulcers 1.Individualized action plan initiated with RN#1 on 1/31/2013. RN#1 was unable to successfully complete the requirements of the individual action plan and has been terminated. Resident #9 wounds were assessed on 1/31/2013, no adverse effects noted. Resident #9 is receiving wound treatment per physician order. 2. All residents are identified to have the potential to be affected by the alleged deficient practice. Nurses in serviced on 2/20/13 per SDC related to wound care including infection control practices and providing treatment as ordered per physician. Nurses will be required to successfully complete skills competencies for treatment/dressing changes and glucometer cleaning during orientation and at least quarterly	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ischium [lower buttock/upper thigh] and had been treated at home with home health and a wound care clinic prior to admission. The clinical record included physician's orders, dated 1/30/13, as follows: "1) (L) [left] ischial wound, flush [with] NS [normal saline] cleanse surrounding [with] NS, pat dry, skin prep surrounding tissue, apply Santyl [debriding agent to eliminate necrotic tissue] to necrotic tissue, pack wound [with] aquacel AG cut to size, cover [with] ABD et secure [with] Meplex foam dressing BID [twice a day] 2) (R) inner buttock wound, (R) gluteal wound, (L) gluteal wound to be cleansed [with] NS, pat dry, skin prep surrounding tissue, hydrogel [gel to promote healing] applied to wound beds et covered meplex foam dressing BID." The following assessments of the resident's areas were in the electronic medical record under events, Pressure Wound Skin Evaluations, documented on 1/30/13 at 8:12 a.m.: "L [left] buttock/gluteal" Present on admission, no Date originally noted, 1/9/13 Stage II [partial thickness loss of		thereafter. All residents with pressure ulcers had wound treatments observed by DNS/designee to ensure physician orders were followed. 1.Nurses in serviced on 2/20/13 per SDC related to wound care including infection control practices and providing treatment as ordered per physician. Nurses will be required to successfully complete skills competencies for treatment/dressing changes and glucometer cleaning during orientation and at least annually thereafter. DNS/Designee will conduct rounds to ensure the pressure ulcer treatments are completed per physician orders. 4.DNS/ designee will complete skills competencies during treatments and/or dressing changes with nurses 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure residents receive treatment and services to prevent infection and promote healing. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of skills competencies will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough...] Granulation 3.3 [centimeters] X 1.1 X 0.1 min [minimum] serous drainage "R [right] inner buttock" documented 1/30/13 8:16 a.m. Present on admission, no Date originally noted, 1/18/13 Stage II Granulation 1.0 X 1.0 X 0.1 red granulation min serous drainage "R [right] buttock/gluteal" documented 1/30/13 8:22 a.m. Present on admission, no Date originally noted 1/22/13 Stage II Granulation inner: 0.8 X 1.0 X <0.1cm [centimeters] outer: 0.7 X 1.2 X <0.1 cm pink granulation min/scant serous drainage Measurements of the left ischium area were documented on 1/28/13 as follows: left ischial 6.3 cm X 2.2 cm X 6.0 cm, moderate exudate, serosanguinous, slight odor,		5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wound bed is red color with yellow slough, slough 50%, granulation 50%, tunneling 12 o'clock measuring 6 cm. Wound edges distinct/defined The resident's admission Minimum Data Set [MDS] assessment, dated 12/27/12, indicated a Brief Interview for Mental Status score of 15 out of 15, indicating no cognitive impairment. The resident required total assistance of two staff for bed mobility, extensive assist of two for transfers, dressing and hygiene. The admission MDS indicated the resident had an unhealed pressure ulcer stage IV [full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling]. The dimensions at the time of the MDS indicated it was 2.4 cm long, 1.0 cm wide and 5.9 cm deep with granulation tissue. The resident's care plan, dated 1/7/13, for impaired skin integrity, included, but was not limited to, the following: Treatment as ordered Air mattress on bed Assess for pain, treat as ordered... Assess wound weekly documenting measurements and description			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Encourage resident to eat at least 75% of meals Incontinent care as needed Labs as ordered Notify MD [medical doctor] of worsening or no change in wound or for signs of infection Observe for signs of infection...described RD [registered dietitian] to assess routinely Supplements as ordered Treatment as ordered Turn/reposition q [every] 2h [hours] and encourage resident to limit time in w/c [wheelchair] to 2 hour intervals Wound healing vitamins as ordered On 1/31/13 at 10:38 a.m., RN #1 and CNA #1 were observed to provide treatment to Resident #9. No dressing was in place at that time. The resident was observed to have one large area on the left ischium, at lease 5 cm wide, with significant depth, not measured at that time, does have some yellow slough in the wound bed. One area below that one had irregular edges, approximately 2.5 cm by 2 cm, with some granulation, some yellow slough. One area on lower right buttock/ischium 1 cm by 1 cm, had red tissue plus some yellow slough. One more area on the right side of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the coccyx observed 1 cm by 1 cm, red tissue with small amount of yellow slough. CNA #1 held the resident over on her right side as far as she could. The nurse took a small bottle of normal saline and poured it over the resident's buttocks and areas. The nurse then obtained Santyl [debriding agent to loosen necrotic tissue] and expelled the ointment onto a gauze pad. She dabbed the ointment onto the 3 smaller areas on the coccyx, left and right lower buttock areas. There was a large amount of Santyl placed on these areas, not just on the necrotic slough areas. She applied the ointment on all three areas using the same gauze pad and Santyl; she did not use a clean gauze pad and fresh Santyl on each area. She did not put any of the Santyl on the necrotic tissue on the left ischial area. She then packed the large ischial area with medicated "roping, identified as Aquacel AG. She used skin prep on the healthy skin around all the areas and then applied two large foam dressings to cover the areas. Upon interview with the Director of Nurses on 1/31/13 at 11:50 a.m., she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the Santyl should be put only on the necrotic tissue and should have been used on the large wound necrotic areas as ordered. The hydrogel should have been used on the smaller wounds as ordered. The procedure for Dressing change, dated 1/2010 and reviewed 9/2012, was provided by the Director of Nurses on 2/7/13 at 9:15 a.m. The procedure included, but was not limited to, the following: Verify resident and physician orders Provide privacy and explain procedure... Set up clean field to ensure easy access to supplies Put on gloves Remove old dressing... Remove gloves and discard Perform hand hygiene Put on gloves Initiate wound care according to the physician order: "Wound care requirements: a) Cleanse away debris or drainage from the wound b) Cleanse from center of wound outward c) Cleanse in one direction d) Use a separate swab/gauze for each cleansing stroke e) If drain present, cleanse using a circular motion starting near the drain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	moving outward f) Measure wound as needed" Remove gloves and discard Perform hand hygiene Put on gloves Apply new dressing according to the physician orders... 3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure a resident with an indwelling urinary catheter received services according to the Physician's order, in that, 1 of 1 residents reviewed for having an indwelling urinary catheter, in a sample of 3, did not have the catheter changed according to the Physician's order. (Resident #B) Findings include: The clinical record of Resident #B was reviewed on 01/30/13 at 1:58 p.m. The Physician Admission Orders dated 08/09/12 included, but was not limited to, the following order "...change f/c [indwelling urinary catheter] q [every] month et [and] prn [as needed] occlusion ..."	F0315	**F315** No catheter, prevent UTI, restore bladder 1. Resident B discharged from facility on 1/17/13. 1.All residents requiring the use of indwelling urinary catheter have the potential to be affected by the alleged deficient practice. An audit was completed of the identified resident's records to ensure that catheters had been changed and/or were scheduled to be changed in accordance to current physician order and plan of care. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians orders. 3. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians' orders. Catheters will be maintained and changed per physicians' orders by DNS/designee monitoring the	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The August 2012 TAR [Treatment Administration Record] lacked any documentation the catheter had been changed between 08/09/12 and 08/31/12. The September 2012 TAR lacked any documentation the catheter had been changed between 09/01/12 and 09/19/12. The TAR included handwritten notes "changed on 09/19/12" and "Change Foley cath [an indwelling urinary catheter] on 09/28/12 then q 6 weeks. due again Nov. 9, 2012." The date of Nov 9, 2012 had been crossed through and an undated, handwritten note above indicated, "Oct 31st 2012." (The time frame between catheter changes equaled 6 weeks.) A physician telephone order dated 09/19/12 indicated an order for "...change Foley catheter every 6 weeks..." The October 2012 TAR included, but was not limited to, an order for "Change Foley catheter every month and as needed occlusion." The entry included a handwritten note that indicated, "changed 09/19/12 and due nov. 9" The TAR lacked any documentation the catheter had been		TAR. DNS/designee will monitor by reviewing physician orders to ensure catheters are changed per order. DNS/Designee will ensure catheter care will be included in the residents' comprehensive plan of care. 4. DNS /designee will complete catheter monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that catheters are changed according to physicians order. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of catheter monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	changed during October 2012. The November 2012 TAR included, but was not limited to, an order for "Change Foley catheter every month and as needed occlusion." The TAR indicated the catheter had been changed on November 9, 2012 (The time frame between catheter changes equaled 7 weeks and 2 days) A Care Plan for indwelling catheter dated 10/29/12 included, but was not limited to, an intervention of, "...change catheter per MD order..." During an interview on 02/05/13 at 8:30 a.m. the DoN [Director of Nursing] indicated she could provide no documentation the catheter had been changed between 08/09/12 and 09/19/12 or between 09/28/12 and 11/09/12. She further indicated, at that time, it was standard practice for the facility to change the catheter according to the Physician's orders. 3.1-41(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure medications administered for pain included an assessment of pain intensity or were monitored for effectiveness for 1 of 10 residents (Resident #63) and failed to ensure anti-anxiety, anti-depressant, and anti-psychotic medications were considered for gradual dose reduction for 1 of 10 residents (Resident #32) reviewed for unnecessary medications, in the sample of 10 who	F0329	**F329** Drug regimen is free from unnecessary drugs 1.Resident #63 seen by nurse practitioner on 2/1/13, new orders received related to pain management. Resident #32 medication regimen reviewed with physician for possible dose reduction, adjustments made as indicated. 2.All residents have the potential to be effected by the alleged deficient practice. Residents have been assessed for pain. Those residents experiencing	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	met the criteria. (Resident #63, Resident #32) Findings include: 1. The clinical record of Resident #63 was reviewed on 01/30/13 at 11:05 a.m. The record indicated the diagnoses included, but were not limited to, PVD [Peripheral Vascular Disease], chronic venous stasis, and neuropathy. Resident #63 was observed on 01/29/13 at 11:30 a.m. lying in bed. During an interview at that time, Resident #63 indicated he occasionally experienced pain. The most recent Quarterly MDS [Minimum Data Set Assessment] dated 01/02/13 indicated Resident #63 had no cognitive impairment. The February 2013 Physician's Order Recap included, but was not limited to, an order dated 09/25/12 for Hydroco/Acetamin [Lortab] [a narcotic pain medication] 5-325 mg [milligrams] Take one tablet po [by mouth] every 6 [six] hours prn [as needed] for pain. The most recent Pain Assessment dated 12/19/12 indicated Resident		pain have been provided pain medication as ordered and are monitored for the effectiveness of pain medication. All residents receiving psychotropic medication are scheduled for pharmacist review. Nurses were in-serviced on 2/18/13 per SDC regarding utilization of pain scale, PRN medication administration and follow-up evaluation for effectiveness of medication administered. Nurses were in serviced on 2/26/13 per SDC related to addressing pharmacy recommendations and considering gradual dose reduction to avoid unnecessary medications. 3. Nurses were in-serviced on 2/18/13 per SDC regarding utilization of pain scale, PRN medication administration and follow-up evaluation for effectiveness of medication administered. Assessments will be completed prior to the administration of PRN medication and an evaluation by licensed staff will be completed. Nurses were in serviced on 2/26/13 per SDC related to addressing pharmacy recommendations and considering gradual dose reduction to avoid unnecessary medications. Pharmacy recommendations will be reviewed with the physician monthly and placed on the residents' charts. Pharmacy will be in serviced by the corporate consultant on the gradual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#63 was interviewable and experienced moderate pain occasionally r/t [related to] BLE [Bilateral Lower Extremity] stasis ulcers. The January 2013 MAR [Medication Administration Record] indicated Resident #63 received Lortab prn on 01/01/13 (twice), 01/02/12, 01/04/13, 01/06/13, 01/07/13, 01/10/13, 01/11/13, 01/15/13, 01/16/13, 01/17/13, 01/18/13. 01/21/13, 01/22/13, 01/24/13, 01/25/13, 01/28/13, 01/29/13, and 01/30/13. The Nurse's medication notes indicated Resident #63 had Lortab administered on 01/01/13 at 1600 [4:00 p.m.] The nurses medication note lacked any documentation that Lortab had been administered or monitored a second time on 01/01/13. The Lortab count sheet for the time period of 12/09/12 through 02/05/13 indicated a Lortab had been administered between 01/01/13 at 1600 [4:00 p.m.] and 01/02/13 0210 [2:10 a.m.] A Nurse's medication note dated 01/07/13 at 0800 [8:00 a.m.] indicated Resident #63 received Lortab for "c/o [complaint of] pain all over, arthritic."		reduction schedule for psychotropic medications. Social service will complete a behavior review monthly for psychotropic medications including the date of the last gradual dose reduction. Information will be reviewed by the IDT for recommendations to the clinician. 4.DNS/designee will complete the pain management monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months. DNS/ designee will complete the unnecessary medication monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that gradual dose reductions are considered and addressed. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of the pain management monitoring tool and unnecessary medication monitoring tool will be completed monthly and monitored in QA for a minimum of 6 months. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The note lacked any documentation of pain intensity or follow up monitoring. An untimed Nurse's medication note dated 01/10/13 indicated Resident #63 received Hydro/Acetamin 5/325 for "c/o general discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/11/13 at 2200 [10:00 p.m.] indicated Resident #63 received Lortab for "c/o general pain and discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/15/13 at 1300 [1:00 p.m.] indicated Resident #63 received Lortab for "c/o shoulder pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/16/13 at 1400 [2:00 p.m.] indicated Resident #63 received Lortab for "c/o arthritic pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/17/13 at 1420 [2:200 p.m.]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident #63 received Lortab for "c/o shoulder pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/18/13 at 1415 [2:15 p.m.] indicated Resident #63 received Lortab for "c/o shoulder pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/21/13 at 2215 [10:15 p.m.] indicated Resident #63 received Lortab for "c/o pain all over." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/22/13 at 1300 [1:00 p.m.] indicated Resident #63 received Lortab for "c/o shoulder pain." The note lacked any documentation of pain intensity or follow up monitoring. A care plan dated 12/11/12 for Pain related to Osteoarthritis included, but was not limited to, interventions of , "document use of prn medications" During an interview with the DoN [Director of Nursing] on 02/05/13 8:30 a.m., she indicated she could not provide any further documentation r/t			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[related to] the resident's pain intensity or follow-up monitoring. She further indicated, at that time, when giving prn medications, the nursing staff should assess the intensity of the pain and monitor the effectiveness of the medication. A policy and procedure for Pain Management provided by the DoN on 02/05/13 at 9:50 a.m. indicated, "...2. ...Interviewable resident...given based upon the intensity of the pain...7. Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented..." 2. Resident #32 was observed to be sleeping in a chair in the activity area on 1/30/13 at 11:00 a.m. The resident was observed to be in a dining/activity area for exercise activity. She was very sleepy looking, and not participating in the activity. At 10:27 a.m. on 1/31/13, the resident was observed in her room in her chair sound asleep. Resident #32's clinical record was reviewed on 1/31/13 at 10:10 a.m. The resident was admitted to the facility on 7/15/11 with diagnoses including, but not limited to,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nonorganic psychosis, anxiety state, depression, neuralgia, hypertension, dysrhythmia, congestive heart failure, cerebrovascular disease, and arthropathy. The physician's orders, signed 1/29/13, included, but were not limited to, the following: Alprazolam [antianxiety] 0.25 mg 1 (one) po daily at bedtime "hold for sedation" since 7/15/11 Lexapro [antidepressant] 20 mg po daily Risperidone [antipsychotic] 0.25 mg one twice a day since 8/25/11 Resident #32's annual Minimum Data Set [MDS] assessment, dated 6/12/12, indicated the resident was receiving an antianxiety medication and an antidepressant medication but failed to indicate the resident was receiving an antipsychotic medication. Resident #32's quarterly MDS, dated 11/21/12, indicated the resident was receiving an antianxiety medication and an antidepressant, but failed to indicate the resident was receiving an antipsychotic medication. Resident #32 had a care plan, dated 7/25/11 for being at risk for adverse side effects related to use of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychotropic medication. Interventions included, but were not limited to, the following: Administer meds as ordered, observe for effectiveness AIMS [assessment for tremors and associated side effects of psychotropic medication] assessment two times per year Document side effects as observed and notify MD Observe for side effects antipsychotic meds and non-antipsychotic meds Pharmacist to review meds routinely On 2/1/13 at 9:30 a.m., pharmacy recommendations were requested from the Director of Nurses [DoN] for the past year for Resident #32. She provided a report at 11:00 a.m. on 2/1/13, indicating "no recommendations" in October and November, 2012 and one recommendation dated 12/11/12 regarding routine artificial tears and routine fluticasone [nasal steroid spray]. She indicated there were no other recommendations she could find. Review of nursing progress notes, on 2/5/13 at 1:00 p.m., indicated the following: 2/4/13 8:44 a.m. "Resident hard to arouse this AM. Wakes up then goes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back to sleep. Awaken constantly during breakfast and reminded to eat. Resident would eat when fed by staff..." On 2/5/13 at 1:05 p.m., the resident was observed on the unit, seated on a couch. Her eyelids were drooping. 3.1-48(a)(3) 3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure recipes were followed for 6 of 6 pureed diets, in that the amount of spaghetti sauce pureed was not according to the recipe. (Residents #1, #10, #17, #93, #57, #52) Finding includes: Cook #1 was observed preparing pureed spaghetti sauce on 2/1/13 at 10:20 a.m. She indicated she was preparing for 10 servings and was consulting a recipe for pureed spaghetti sauce for 10 servings. She placed 1 quart and 3/4 cup of sauce into the processor. She then added 1 tablespoon of thickener. She processed the mixture and then poured it into a steam table pan and indicated she was done. It was requested for her to recheck the recipe. The recipe was consulted again at that time and indicated 1 and 3/4 quarts, plus 1/2 cup were to be	F0363	**F363** Menus meet res needs/ prep in advance/follow 1. The amount of spaghetti sauce needed, according to the recipe, was added to the pureed food prior to being served to the residents. Recipes are being followed when preparing pureed foods. 2. All residents have the potential to be effected by the alleged deficient practice. Dietary staff was in serviced on 2/8/13 per CDM related to preparing puree diets and following recipes. Recipes are being followed when preparing pureed foods. 3. Dietary staff was in serviced on 2/8/13 per CDM related to preparing puree diets and following recipes. Recipes will be followed to meet the nutritional needs of the residents. CDM/ designee will monitor the preparation of pureed foods during each meal to ensure the pureed recipes are followed.	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	added. She then added the additional 3/4 quart of sauce and finished the process. The recipe was provided by the Dietary Service Manager on 2/7/13 at 10:44 a.m. The recipe indicated for 10 servings the amount of spaghetti meat sauce was to be "1 3/4 Quart 1/2 Cup." Review of the Nurse Aide Assignment sheets on 2/1/13 at 11:00 a.m., provided by the Director of Nurses on 1/28/13 at 10:55 a.m., indicated the following residents received puree diets: Residents #1, #10, #17, #93, #57, #52. 3.1-20(i)(4)		1.DM/designee will complete food preparation monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months. Results of food preparation monitoring tool will be monitored in the monthly CQI meeting for a minimum of 6months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food served was palatable and at the proper temperature, for 3 of 3 sampled residents in a sample of 6 who met the threshold. (Resident #140, Resident #141, Resident #142) Findings include: During stage I survey confidential resident interviews, the following information was provided: Resident #140 indicated on 1/28/13 at 2:46 p.m., the food he received was usually cold, "tastes like junk, wouldn't feed it to my dog." Resident #141 indicated, on 1/29/13 at 9:27 a.m., the food was never hot, "lukewarm is the best I can give you." Resident #142 indicated on 1/29/13 at 9:12 a.m. the food was cold when she received it. The tray service was observed on 2/1/13 beginning at 7:28 a.m. At that time, the first cart was sent to Auguste's Cottage, the Alzheimer's	F0364	**F364** Nutritive value/appear, palatable/prefer temp 1. Food is being served at palatable temperatures CDM/designee monitoring the temperatures at each meal in each dining room and monitoring room trays temperatures. 1.All residents have the potential to be effected by the alleged deficient practice. Dietary staff were in serviced on 2/28/13 per CDM related to food temperature and documentation protocol. CDM/ designee will monitor the temperatures at each meal in each dining room and monitoring the room tray temperatures. Insulated bowls will be used to ensure food is served at appropriate warm temperature. 3. Dietary staff were in serviced on 2/28/13 per CDM related to food temperature and documentation protocol. Food temperatures will be obtained on the food line and the last hall tray to ensure food is served at appropriate temp. The DM will review the food temperatures to ensure safe and palatable food is	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Unit dining area. The last tray was served at 8:05 a.m. Temperatures were checked at that time. The scrambled eggs measured 90 degrees and felt cool to touch. The second cart to the Cottage was sent out at 7:35 a.m. At 8:00 a.m., the trays had been served and the residents were eating. Interview with Resident #142 indicated the food was warmer than usual but still cool. Residents #140 and #141 resided on the A hall and were interviewed at 8:05 a.m. on 2/1/13 and indicated their food was "lukewarm" [#140] and "ok today" [#141]. On 02/01/13 at 10:30 a.m., the documented temperatures of the eggs on the steam table were reviewed in the kitchen. The eggs were 185 degrees Fahrenheit on the steam table prior to service, according to the documentation. 3.1-21(a)(2)		served. CDM/designee will conduct resident interviews during meals to ensure resident satisfaction with food temperature and taste. 4. DM/designee will complete meal service observation tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that food is served at the proper temperature. Results of meal service observation tool will be monitored in the monthly CQI meeting for a minimum of 6 months; if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure the dishwasher water temperatures were monitored to ensure temperatures met the required specifications for sanitization of dishes, for 1 of 1 mechanical dishwasher in the facility. This had the potential to affect 94 residents who received food from the kitchen. Finding includes: On 2/1/13 at 10:35 a.m., the dishwasher was observed running. Dietary Aide #1 was observed in the dish room. A thermometer gauge was observed below the dishwasher. An attempt was made to read the water temperature. Dietary Aide #1 indicated the thermometer did not work. He indicated he had to check and reset the booster heater every third wash. He indicated the temperatures it was supposed to be were on the side of the machine. He provided a documentation book	F0371	**F371** Food procure, store/prepare/serve 1. The dishwasher temperatures are meeting the required specification for sanitizing dishes by purchasing and installing a new thermostat and high limit switch in the water heater booster to ensure the water is at appropriate temperature. 2. All residents have the potential to be effected by the alleged deficient practice. Dietary staff were in serviced 2/8/13 per CDM related to dishwasher temperature monitoring. Three times daily the water temperatures are checked and the temps are logged. This log is monitored by Dietary Manager/Designee daily. 3. Dishwasher temps will be obtained and documented on the dishwasher temperature log to be reviewed by the DM. Dietary Manager/Designee will monitor the log daily. If temps are not appropriate, appropriate action will be taken.	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	where the temperatures were documented. The temperatures were documented daily from 1/11/13 through 2/1/13 on one page. The was temperature was documented as 120 degrees, the rinse temperature was documented as 140 degrees and the sanitizer concentration was documented as 75 parts per million. Dietary Aide #1 indicated he did not have a functioning thermometer to check the temperature but knew it was hot enough by feel. He indicated the people who installed the dishwasher had told him to write down 120 and 140 degrees in the book. At 10:50 a.m. on 2/1/13, water temperatures were checked as water came out of the dishwasher. The maximum temperature reached on the first run was 96 degrees during the wash and 109 degrees during the rinse cycle. On the second run, the maximum temperature reached was 110 degrees on the wash cycle and 134 degrees on the rinse cycle. The side of the machine indicated the minimum wash and rinse temperature should be 120 degrees and 140 degrees was recommended. The machine used chemical sanitation. The chemical concentration was		4.DM/ designee will complete sanitation tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that dishwasher temperatures meet the required specifications for sanitization of dishes. Results of infection control tool will be reviewed in the monthly CQI meeting for a minimum of 6 months; if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checked and was as recommended. On 2/1/13 at 11:00 a.m., the Dietary Manager was informed of the temperatures not reaching the recommended levels. She indicated she was unaware the thermometer did not work on the side of the equipment. The Dietary Manager indicated the actual temperature of the water should be checked and written down. The temperature of the water during wash and rinse cycle was rechecked at 11:05 a.m. and it reached a temperature of 153 degrees. The Dietary Manager indicated at that time she was having the company who serviced the equipment come out and check it out. The Administrator indicated on 2/6/13 at 2:00 p.m., regarding the dishwasher, the company came in and assessed the dishwasher and indicated the booster needed a new thermostat; this was causing it to shut off on occasion causing an inconsistency in temperatures. Temperatures were now being checked to ensure water reached appropriate levels and the new thermostat was being overnighted.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The policy and procedure for Recording Dish Machine Temperature/Sanitizer, dated 02/02 and revised 04/11, was provided by the Dietary Service Manager on 2/7/13 at 10:44 a.m. The policy and procedure included, but was not limited to, the following: "Dishwashing staff will monitor and record dish machine temperatures and/or sanitizer concentration to assure proper sanitizing of dishes. 1. Dietary Services Manager will provide a log to be posted near the dish machine 2. The Dietary Services manager will train the staff to monitor the dish machine temperatures throughout the dishwashing process. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles and the sanitizer concentration (if appropriate) at each meal. 4. The Dietary Services Manager will spot check these logs to assure the temperatures/sanitizer concentrations are appropriate, and staff are monitoring dish machine temperatures. 5. Dishwashing staff will be trained to report any problems with the dish machine to the Dietary Services Manager as soon as they occur.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6. The Dietary Services Manager will promptly assess any dish machine problems and take corrective action to assure appropriate sanitization of dishes." 3.1-21(i)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Resident #29's diagnoses include, but are not limited to, bipolar disorder, anemia, uterine cancer, anxiety, chronic kidney disease, and an abdominal aortic aneurysm. The annual MDS [Minimum Data Set] assessment, dated 4/6/12, and the quarterly MDS assessment, dated 11/14/12, indicated the resident had	F0412	**F412** Routine/emergency dental services in nfs 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/ assessed if they need dental services. Consents were obtained for residents wishing to see a dentist. Facility audit completed to ensure that dental consents have been obtained and dental services scheduled as indicated. IDT and nurses in serviced on 2/26/13 per SDC related to dental services. 3. IDT and nurses in serviced on	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a BIMS [brief interview for mental status] score of 15 out of 15, indicating the resident did not have any cognitive impairment. The annual MDS assessment, dated 4/6/12, indicated Resident #29 had no dental problems. The assessment did not indicate the resident had dentures. The quarterly MDS, dated 11/14/12, did not indicate any dental issues. Resident #29 was interviewed on 1/29/13 at 9:17 a.m. On interview the resident indicated she had loose dentures. Resident #29 indicated her dentures were at least 20 years old and she had not been to the dentist in quite some time. The resident indicated she had been able to chew without difficulty but probably needs some adjustments to her dentures. Interview with SW #1 on 2/1/13 at 10:44 a.m., indicated the resident had not had a dental visit since being admitted to the facility. SW #1 indicated she did not realize the resident had any dental issues. SW #1 indicated she could not locate the consent for dental services that is signed when the resident is admitted to the facility. SW #1 indicated she would need to follow up with the resident's charts to ensure the		2/26/13 per SDC related to dental services. Social Service Director will review all dental consents to ensure all residents are receiving dental services as needed. Any refusal of consent, the Social Service director will follow up with the resident to inquire about dental services. 4. DNS/designee will complete assessment monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that comprehensive assessments accurately reflect the residents' status, including but not limited to skin issues, psychoactive medications and dental status. SSD/designee will complete dental service monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure dental consents and services are provided as indicated. Results of assessment monitoring tool and dental service monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents had their consents signed for services and she would speak with the resident's family to allow the resident to have a dental appointment. SW #1 indicated the resident could be visited by a dentist in the facility or the resident could visit their own dentist. Interview with SW #1 on 2/7/13 at 9:56 a.m., indicated she had looked through the resident's medical record and was unable to locate where the resident had a dental visit nor was she able to locate a consent for dental services. Interview with MDS Coordinator on 2/1/13 at 11:20 a.m., indicated he normally checks the resident's chart after they are admitted in order to complete the MDS. 2. Resident #111's record was reviewed on 1/30/13 at 1:00 p.m. Resident #111 had a diagnoses of, but not limited to, dementia,anxiety, hypertension, and hyperlipidemia. Resident #111's admission MDS, dated 4/27/12, indicated the resident had no dental issues. The quarterly MDS, dated 12/21/12, also indicated the resident did not have any dental issues.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #111's family and POA [power of attorney] was interviewed on 1/28/13 at 12:41 p.m. Resident #111's family/POA indicated the resident had loose teeth and had lost some of her teeth since coming to the facility. She felt the resident's gums had "shrank." Resident #111's family/POA indicated the resident had visited the dentist in the past but had not had a dental visit since her admission to the facility in April, 2012. Interview with the SW [Social Worker] on 2/1/13 at 10:44 a.m., indicated the resident had not had a dental visit since being admitted to the facility. SW #1 indicated she did not know the resident had any dental issues. SW indicated she could not locate the consent for dental services that is signed when the resident is admitted to the facility. SW #1 indicated she would need to follow up with the resident's charts to ensure the residents have their consents signed for services and she would speak with the resident's family to allow the resident to have a dental appointment. SW indicated the resident could be visited by a dentist in the facility or the resident could visit their own dentist.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with SW on 2/7/13 at 9:56 a.m., indicated she had "looked through" the resident's medical record and was unable to locate where the resident had a dental visit or a consent signed for dental services. Interview with MDS Coordinator on 2/1/13 at 11:20 a.m., indicated was hired by the facility as an assistant MDS Coordinator in April, 2012, and after beginning employment, the previous MDS Coordinator left. 3.1-24(a)(1) 3.1-24(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on observation, interview, and record review, the facility failed to ensure pharmacy recommendations were addressed for 3 of 10 residents reviewed for unnecessary medications, in the sample of 10 who met the criteria. (Resident #44, Resident #50, Resident #32) Findings include: 1. The clinical record of Resident #44 was reviewed on 02/05/13 at 8:10 a.m. The record indicated the diagnoses included, but were not limited to, Hypertension [high blood pressure] and Osteoarthritis. The February 2013 Physician Order Recap included, but was not limited to, the following orders "...Bumetanide [a medication for high blood pressure] 1 mg [milligram] tab Give 2nd dose after lunch if edema if patient	F0428	**F428** Drug regimen review, report irregular, act on 1. Pharmacy recommendations have been addressed by the physician for resident #44, #50 and #32. 2. All residents have the potential to be affected by the alleged deficient practice. Facility audit of pharmacy recommendations pending response was completed and addressed with physicians as indicated. Nurses were in serviced on 2/26/13 per SDC related to addressing pharmacy recommendations and considering gradual dose reduction to avoid unnecessary medications. Pharmacy recommendations are received by the DNS monthly. DNS forwards recommendation to attending physician. The physician signs the order for the recommendation if agrees. The pharmacy is notified of the physician order. The DNS compares the original recommendation to the orders received, to ensure are recommendations have been addressed. Pharmacist reviews recommendations to ensure all	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	want...Oxycodone IR [a narcotic medication for pain] 5 [five] mg tablet take 1[one]-2 [two] tablets (5 [five]-10 [ten] mg) every 4 [four] hours as needed for pain..." The Note To Attending Physician/Prescriber dated 12/11/12 included, but was not limited to, the following Pharmacy Recommendations, "...Bumetianide needs frequency...Oxycodone: CMS [Centers for Medicare and Medicaid Services] does noti [sic] support ranges please [sic] chose [sic] either 1 [one] or 2 [two] tiabletis [sic]...". The note lacked any documentation the physician had been notified of the Pharmacy recommendation. During an interview on 02/05/13 at 8:55 a.m. the DoN [Director of Nursing] indicated the pharmacy recommendations had not been addressed and still needed to be followed up on..." During an interview on 02/07/13 at 2:49 p.m. The DoN indicated the facility did not have a policy related to pharmacy recommendations. She further indicated, at that time, pharmacy recommendations should be addressed within 30 (thirty) days.		recommendations have been addressed. 3. Nurses were in serviced on 2/26/13 per SDC related to addressing pharmacy recommendations and considering gradual dose reduction to avoid unnecessary medications. Pharmacy recommendations will be addressed with the physician monthly and placed on the residents' charts. The DNS will ensure that the pharmacy consultant recommendations are completed. Pharmacy consultant will review previous month recommendations to ensure there is appropriate follow up. 4. DNS/ designee complete unnecessary medication monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that pharmacy recommendations, including gradual dose reductions are considered and addressed. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of unnecessary medication monitoring tool will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Resident #32 was observed to be sleeping in a chair in the activity area on 1/30/13 at 11:00 a.m. Resident #32's clinical record was reviewed on 1/31/13 at 10:10 a.m. The resident was admitted to the facility on 7/15/11 with diagnoses including, but not limited to, nonorganic psychosis, anxiety state, depression, neuralgia, hypertension, dysrhythmia, congestive heart failure, cerebrovascular disease, and arthropathy. The physician's orders, signed 1/29/13, included, but were not limited to, the following: Alprazolam [antianxiety] 0.25 mg 1 [one] po daily at bedtime "*hold for sedation*" since 7/15/11 Lexapro [antidepressant] 20 mg po daily Risperidone [antipsychotic] 0.25 mg one twice a day since 8/25/11 Resident #32 had a care plan, dated 7/25/11 for being at risk for adverse side effects related to use of psychotropic medication. Interventions included, but were not limited to, the following: Administer meds as ordered, observe for effectiveness AIMS [assessment for tremors and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	associated side effects of psychotropic medication] assessment two times per year Document side effects as observed and notify MD Observe for side effects antipsychotic meds and non-antipsychotic meds Pharmacist to review meds routinely On 2/1/13 at 9:30 a.m., pharmacy recommendations were requested from the Director of Nurses [DoN] for the past year for Resident #32. She provided a report at 11:00 a.m. on 2/1/13, indicating "no recommendations" in October and November, 2012 and one recommendation dated 12/11/12 regarding routine artificial tears and routine fluticasone [nasal steroid spray]. She provided no further information to indicate the pharmacist had made any recommendations regarding the resident's psychoactive medications in the past 12 months. The DoN indicated at that time she could not find any further recommendations for review. 3. Resident #50's clinical record was reviewed on 1/30/13 at 11:05 a.m. The resident was admitted to the facility on 12/2/12 with diagnoses including, but not limited to,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hyperlipidemia, dementia and osteoporosis. The resident was transferred out to a geriatric psychiatric unit on 12/5/12 and returned to the facility on 12/21/12. The record included, but was not limited to, physician's orders, dated 12/24/12 at 10:30 a.m., for the following medications: Haldol [antipsychotic medication] 5 milligrams [mg] at 1600 [4:00 p.m.] that date and every 6 hours as needed for extreme anxiety/agitation. Geodon [antipsychotic medication] 40 mg by mouth daily to start 12/25/12. Upon admission 12/21/12, the resident also had orders for Lorazepam [antianxiety medication] 0.5 mg by mouth every 4 hours as needed. Review of the Medication Administration Record indicated the resident received lorazepam on 12/23/12, 12/25/12, and 12/26/12. Additional physician's orders included, but were not limited to, the following: "1/2/13 ABH Gel [topical preparation containing Ativan [antianxiety], Benedryl [antihistamine], and Haldol [antipsychotic]] Full Strength Topical Q [every] 4 Hrs PRN." For increased anxiety.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/21/12 Olanzapine [Zyprexa, antipsychotic] 5 milligram [mg] tablet by mouth once daily at noon 12/21/12 Olanzapine 10 mg one tablet by mouth once daily at 5:00 p.m. 12/21/12 Diphenhydramine [Benadryl, antihistimine] 25 mg by mouth twice daily A pharmacy recommendation in the clinical record, dated 1/14/13, indicated the following: "Recent fall" "Pt. [patient] is on abh gel which has lorazepam [Ativan], haldol and diphenhydramine...futhrermore (sic), pt is also on prn haldol and ativan tablets and twice daily benadryl. the benedryl has no diagnosis. perhaps it could be lowered to 25 mg in the evening only? If pt needs both the abh gel and the oral ativan and haldol, perhaps the oral ativan could be lowered from q4h prn [as needed] to q6h prn and the haloperidol lowered from 5 mg to 2 mg? Or perhaps one of the oral agents could be dced [discontinued]; although both are prn, as is the gel, there is still the chance of doubling up on them. also pt is on zyprexa 10 mg at 1700. perhaps this could be moved to bedtime to minimize dizziness, drowsiness, sedation?" The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recommendation indicated it was faxed to the physician on 1/14/13. There was no response to the recommendation in the record. There was no indication the pharmacy recommendation was ever acted upon. The Director of Nurses indicated on 2/6/13 at 2:00 p.m., there was no further information regarding the pharmacy recommendation. 3.1-25(i)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observation, interview and record review, the facility failed to	F0441	**F441** Infection control, prevent spread, linens	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure the infection control program was implemented to prevent possible transmission of infections from one resident to another, for 2 of 4 observations of blood glucometer checks on 1 of 3 units (Station I), in that the glucometer was not sanitized between residents. (Resident #9, Resident #137) B. Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed to prevent potential transmission of infection from one wound to another, for 1 of 1 resident with pressure sores, in the sample of 3 residents reviewed for pressure sores. (Resident #9) Findings include: A.1. On 1/31/13 at 11:10 a.m., RN #1 was observed to do a blood glucose check for Resident #137. RN #1 placed glucometer back in a lancet box and took it to the medication cart. She indicated to Resident #137's room-mate, Resident #9, "let me just wash my hands and I'll be back for you." She left the room and used sanitizer on her hands in the hallway. She then went to the cart and set the box with the glucometer in it on top of the medication cart. She checked		1.1. Individualized action plan initiated with RN#1 on 1/31/2013. RN#1 was unable to successfully complete the requirements of the individual action plan and has been terminated. Infection control procedures are followed regarding glucometer usage and cleaning. Resident #9 skin assessed on 1/31/13, no adverse effects noted. Resident #9 is receiving wound treatment per physician order. 2. All residents are identified to have the potential to be affected by the alleged deficient practice. Nurses were in serviced on 2/26/13 per SDC related to infection control practices during wound care and proper sanitizing of glucometers to prevent possible transmission of infection. Skill validations for glucometer cleaning and dressing changes were completed for all nurses. 3. Nurses were in serviced on 2/26/13 per SDC related to infection control practices during wound care and proper sanitizing of glucometers to prevent possible transmission of infection. Nurses will be required to successfully complete skills competencies for treatment/dressing changes and glucometer cleaning during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Medication Administration record [MAR] and then picked up the box with glucometer in it and carried it into Resident #9's bedside and set it on the resident's abdomen. At that time, the nurse was requested to pick up the glucometer and box and leave the room. At the medication cart, she was interviewed regarding any procedures for cleaning/sanitizing the glucometer. She indicated she cleaned the meters if they were soiled or had blood on them. Otherwise, she just did it at the end of her shift. She showed me a sani-wipe in the drawer that she used. She indicated she did not do it every time. "I'm guilty," she stated. At 11:50 a.m. on 1/31/13, the Director of Nurses [DoN] and Administrator were interviewed. They indicated what was observed was not their policy and RN #1 had reported to them what happened. The DoN indicated RN #1 had already been inserviced. At 12:00 noon, they indicated the nurse was not allowed to do any blood glucometer checks until she was monitored and everyone was being re-inserviced. The policy and procedure for Glucose Meter Cleaning and Testing, dated		orientation and at least quarterly thereafter. Rounds will be conducted by DNS/Designee to ensure appropriate glucometer cleaning occurs and infection control is provided during treatment changes. 4. DNS/ designee will complete skills competencies during treatments and/or dressing changes with nurses 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months ensure residents receive treatment and services to prevent infection and promote healing. DNS/ designee will complete skills competencies related to glucometer checks 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that infection control procedures are followed to prevent potential transmission of infection. Failure to comply with guidelines will result in disciplinary action up to and including termination. Results of skills competencies will be monitored in QA for a minimum of 6 months, if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/11, was provided by the Director of Nurses on 1/31/13 at 12:05 p.m. The policy and procedure included, but was not limited to, the following: "11. Wash or sanitize hands. 12. Proceed to resident room with cleaned meter, testing equipment and supplies. 13. Verify resident 14. Place clean paper towel, plastic cup or clean barrier on hard surface. 15. Placed cleaned meter on paper towel, in plastic cup or clean barrier. 16. Put on clean gloves. 17. Cleanse resident's finger tip with alcohol wipe. 18. Allow finger tip to air dry. 19. Insert reagent strip into meter. 20. Prick resident's finger tip with lancet. 21. Obtain single droplet of blood... 23. Wait for results. 24. Check finger for bleeding. 25. Remove gloves 26. Gather meter, used reagent strip, alcohol wipes, paper towel and gloves. 27. Exit room 28. Dispose of used lancet and reagent in sharps container. 29. Dispose of alcohol wipe, paper towel or clean barrier and gloves in trash. 30. Place meter on paper towel on medication cart.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	*Note: If blood is visibly present on the meter, two wipes MUST be used. One wipe to clean i.e. remove visible blood or soiling and second wipe to disinfect. Cleaning meter after use/prior to using on next resident: 31. Wash or sanitize hands. 32. Place clean paper towel, plastic cup or clean barrier on hard surface. 33. Put on gloves. 34. Obtain single-use germicidal wipe, Super Sani-Cloth. 35. Wipe entire external surface of the blood glucose meter with wipe for 2 minutes and ensure meter stays wet for 2 minute time period. 36. Place clean meter on clean paper towel, in plastic cup or clean barrier. 37. Allow meter to dry completely. 38. Dispose of used wipe and dirty paper towel in trash. 39. Remove gloves and dispose in trash. 40. Wash hands..." B.1. Resident #9's clinical record was reviewed on 1/30/13 at 2:00 p.m. The resident was admitted to the facility from the hospital on 12/19/12 with diagnoses including, but not limited to, endometrial cancer and multiple sclerosis. The resident was admitted to the facility with a history of a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chronic pressure area on her left ischium [lower buttock/upper thigh] and had been treated at home with home health and a wound care clinic prior to admission. The resident developed additional areas after admission. The clinical record included physician's orders, dated 1/30/13, as follows: "1) (L) [left] ischial wound, flush [with] NS [normal saline] cleanse surrounding [with] NS, pat dry, skin prep surrounding tissue, apply Santyl [debriding agent to eliminate necrotic tissue] to necrotic tissue, pack wound [with] aquacel AG cut to size, cover [with] ABD et secure [with] Meplex foam dressing BID [twice a day] 2) (R) inner buttock wound, (R) gluteal wound, (L) gluteal wound to be cleansed [with] NS, pat dry, skin prep surrounding tissue, hydrogel [gel to promote healing] applied to wound beds et covered meplex foam dressing BID." On 1/31/13 at 10:38 a.m., RN #1 and CNA #1 were observed to provide treatment to Resident #9. No dressing was in place at that time. The resident was observed to have one large area on the left ischium, at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lease 5 cm wide, with significant depth, not measured at that time, does have some yellow slough in the wound bed. Stage IV area [full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling]. One area below this one had irregular edges, approximately 2.5 cm by 2 cm, with some granulation, some yellow slough. One area on the lower right buttock/ischium 1 cm by 1 cm, had red tissue plus some yellow slough. One more area on the right side of the coccyx was observed as 1 cm by 1 cm, red tissue with small amount of yellow slough. The last 3 areas were stage II [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough...] CNA #1 held the resident over on her right side as far as she could. The nurse took a small bottle of normal saline and poured it over the resident's buttocks and areas. The nurse then obtained Santyl [debriding agent to loosen necrotic tissue] and expelled the ointment onto a gauze pad. She dabbed the ointment onto the 3 smaller areas on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the coccyx, left and right lower buttock areas. There was a large amount of Santyl placed on these areas, not just on the necrotic slough areas. She applied the ointment on all three areas using the same gauze pad and Santyl; she did not use a clean gauze pad and fresh Santyl on each area. She did not put any of the Santyl on the necrotic tissue on the left ischial area. She then wore the same gloves and packed the large ischial area with medicated "roping," identified as Aquacel AG. She used skin prep on the healthy skin around all the areas and then applied two large foam dressings to cover the areas. Upon interview with the Director of Nurses on 1/31/13 at 11:50 a.m., she indicated the nurse should have treated each area separately and followed the orders for treatments. The procedure for Dressing Change, dated 1/2010 and reviewed 9/2012, was provided by the Director of Nurses on 2/7/13 at 9:15 a.m. The procedure included, but was not limited to, the following: Verify resident and physician orders Provide privacy and explain procedure... Set up clean field to ensure easy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	access to supplies Put on gloves Remove old dressing... Remove gloves and discard Perform hand hygiene Put on gloves Initiate wound care according to the physician order: "Wound care requirements: a) Cleanse away debris or drainage from the wound b) Cleanse from center of wound outward c) Cleanse in one direction d) Use a separate swab/gauze for each cleansing stroke e) If drain present, cleanse using a circular motion starting near the drain moving outward f) Measure wound as needed" Remove gloves and discard Perform hand hygiene Put on gloves Apply new dressing according to the physician orders... 3.1-18(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on observation, interview, and record review, the facility failed to ensure facility staff knew the proper procedure in the event of a fire, in that, 1 of 5 laundry staff members did not know the gas supply needed to be turned off in the event of a fire and did not know the location of the gas shut-off valve. Findings include: During the environmental tour on 02/05/13 at 2:00 p.m. Laundry Aide #1 indicated in the event of a fire in the laundry, she would "grab a fire extinguisher and use the phone to call for help right away... I would turn the dryer off with the red stop button on the front of the dryer... these are all electric... if there is a gas shut off they never told me about it." During an interview, at that time, the Maintenance Director was observed to be standing in an open space behind the dryers and indicated the	F0518	**F518** Train all staff emergency procedures/drills 1. A sign was posted in the laundry room to indicate the location of the gas shut off valve and an in-service was initiated with the laundry staff on 2/5/2013 per the Housekeeping supervisor. 2. All residents have the potential to be effected by the alleged deficient practice. Staff in serviced related to location of gas shut off valve to the dryer on 2/26/13 per SDC. 3. Location of the gas shut off valve to the dryer will be reviewed with new employees and has been added to the job specific orientation checklist. 4. Housekeeping supervisor/ designee will complete an emergency preparedness monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, then weekly x 6 weeks and monthly for 3 months to ensure that facility staff know proper procedure in the	03/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dryers were gas fueled and was able to show the exact location of the gas shut off valve. The gas shut off valve was observed on 02/05/13 at 2:15 p.m., to be located behind an unmarked closed door, on an exposed pipe in the ceiling. An unmarked, twisted hanger was observed to be hanging down from the turning mechanism. The employee file of Laundry Aide #1 was reviewed on 02/05/13 at 2:30 p.m. The employee file indicated Laundry Aide #1 had been inserviced on dryer safety upon hire. The employee file lacked any documentation that Laundry Aide #1 had been inserviced on the emergency gas shut off in the laundry. During an interview on 02/05/13 at 2:40 p.m. the Housekeeping Supervisor stated, "I thought she knew, I guess she doesn't, I will inservice everybody right away and mark the gas shut-off pull..." During an interview on 02/05/13 at 3:50 p.m. the Housekeeping Supervisor indicated the proper procedure to follow in the event of a fire was to turn the gas off		event of a fire. Results of the emergency preparedness monitoring tool will be monitored in QA for a minimum of 6 months; if a threshold of 95% is not met an action plan will be developed. 5. Completion Date: March 9 th , 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately. During an interview on 02/06/13 at 9:01 a.m., the Housekeeping Supervisor indicated new employees were taught about fire safety on the dryer but, it did not include instructions for emergency gas shut off. He further indicated, at that time, he used the General Fire Action Plan and the Disaster Manual during new employee orientation. The General Fire Action Plan and the Disaster Manual provided by the HFA [Health Facilities Administrator] on 02/07/13 at 1:30 p.m. lacked any documentation related to shutting off the gas supply in the laundry in the event of a fire. 3.1-51(b)			